



NGO Networks
for Health

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PREVENTING STIs

At a glance

This issue of *At A Glance* reports on Dr. James Shelton's presentation on why syndromic management of vaginal discharge as a tool for diagnosing STIs has not been successful and the need, therefore, to return to—or at least very selectively combine syndromic management with—a renewed emphasis on prevention. Jim, a senior medical scientist with USAID's Center for Population, Health and Nutrition, identified the weaknesses of the syndromic approach and described a three-pronged strategy to prevent the spread of HIV and other STIs. According to Jim, "the vast human misery caused by HIV and other sexually transmitted infections (STIs) provides a compelling rationale for enlisting the support of family planning and related health program efforts against such diseases. Yet the main tool that FP/RH programs have used—syndromic management of vaginal discharge—has been a major disappointment."

But there were technical problems with syndromic management: in some cases, different infections present with the same symptom (e. g., a vaginal discharge), opening up the possibility of misdiagnosis and unnecessary, wasteful treatment. Jim cited one study, which showed that 85% of women diagnosed with chlamydia/gonorrhea using the syndromic approach did not in fact have either infection. Another limitation of this approach is the fact that other infections present without symptoms and normally cannot be identified without the use of sophisticated diagnostic techniques (i.e., laboratory tests), which are beyond the scope of many clinics.

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WEAKNESSES OF SYNDROMIC MANAGEMENT

Technical Problems

In resource-poor countries, syndromic management seemed to make sense. Rather than relying on sophisticated laboratory procedures to diagnose specific STIs, providers could use an "algorithm of decision points and specific regimens to treat such syndromes as vaginal discharge, urethral discharge (in men), genital ulcers, and pelvic pain." This appeared to be a simple and effective approach, i.e., a genital ulcer indicated syphilis or chancroid; urethritis (in males) was likely to indicate gonorrhea and/or chlamydia.

Distinguishing between curable and noncurable STIs is another important factor in managing these diseases. If an STI is caused by a bacteria, then it is typically curable and can be treated with antibiotics. If it is caused by a virus, then it is not curable. As STIs caused by either organism can present with the same symptoms, once again, care givers may need sophisticated laboratory tests to make a differential diagnosis.

The point Jim makes here is that *all* STIs, whether curable or not, are preventable.

Poor Implementation

Even under the best of circumstances, syndromic management is only as effective as the people charged with implementing it. In many cases, their performance is substandard. Providers often fail to ask about symptoms or risk factors, for example, or fail to examine the client properly—or at all. They sometimes fail to follow the clinical algorithm and substitute their own clinical diagnosis (which may be incorrect), or they may neglect to treat the client with the proper drug or neglect to counsel clients on how to take the drugs. Often providers fail to counsel clients about prevention, fail to provide condoms, or fail to discuss partner notification.

Other Weaknesses

The drawbacks of syndromic management notwithstanding, Jim explained, “any case-treatment approach in the general population has severe limitations.” According to WHO, there are approximately 150 million new cases each year of gonorrhea and chlamydia alone. And yet a relatively small number of these cases are actually identified, treated properly, cured, and have their partner successfully treated and cured even *in the best service delivery system*. The cost of drugs presents another daunting problem as do the programmatic costs involved in training, supervision, management, quality control, physical space, surveillance, and evaluation.

BACK TO THE BASICS

The best way to help those millions of people infected with STIs each year is to prevent them from getting infected in the first place. Jim believes it is time to reemphasize prevention, but in a more strategic manner which takes advantage of the

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resources of existing family planning and related programs, not just the ‘clinical’ resources. “We need to deal with all STIs,” Jim explained, “rather than just a few. We must take advantage of the special dynamics of STI transmission...[and] implement an approach that helps protect everyone.” The costs involved can be kept low by building on ongoing family planning and maternal and child health activities.

A Three-Pronged Strategy

Jim Shelton presented a three-pronged, broad-based prevention strategy for STIs aimed at high transmitters, men, and the general population.

High Transmitters: Individuals such as commercial sex workers, truck drivers, and military recruits, constitute “a powerful and dynamic locus of infection and reinfection that then ‘bridges’ into the general population.” These individuals are known as “high transmitters” because of the number of sexual contacts they have and the fact that they engage in high-risk sexual behavior. They are a crucial source of infection; without them, certain STIs could not be

sustained in such high numbers in the general population. In this regard, a recent World Bank publication notes that 500 commercial sex workers would be expected to infect 10,000 partners in a year.¹ Therefore we cannot ignore this segment of the population in our prevention efforts.

Thailand's "100% condom use" campaign is a prime example of interventions with high transmitters and their clients – the bridge to the general population – that had profound results. This campaign aggressively promoted the use of condoms among commercial sex workers, with an education component aimed at clients, and resulted in a decrease of almost 80% of all five reportable STIs among men in Thailand.

Because of the crucial role high transmitters play in the dynamic of STIs, curative treatment (including syndromic management in spite of its shortcomings) should be provided to this particular population. This treatment could be provided through local family planning and maternal child health clinics in locations that serve the high transmitter population places (i.e. military installations and known truck routes). Those people responsible for developing new sites/programs should also keep this population in mind and develop their services accordingly.

Men: One of the best ways to help protect women against STIs is to promote STI prevention among men. One appeal to men is in eliminating the painful symptoms caused by STIs. Another is through their sense of virility, using the fact that STIs can pose a threat to their ability to reproduce and can also have an effect on their progeny. Since men are less likely to frequent family planning clinics, social marketing of condoms is one of the few practical ways to reach them. Another strategy is through workplace awareness programs and clinics. In any behavior change strategy aimed at men, condom use should be one of the primary messages.

The General Population: Establishing a community-wide norm of prevention is essential to the success of any STI prevention program. Awareness raising and other education efforts, such as mass media spots, soap operas, docudramas, and sports promotions, can be very effective in motivating the general public. STI awareness and education can also be carried out through traditional family planning and MCH service delivery programs, of course, but this approach has its limitations: it reaches relatively few women; there may be a scarcity of staff time and resources; providers are often ignorant about the topic; and the topic more often than not is taboo in many countries.

Mwanza vs. Rakai: Two Different Experiences

In the Mwanza area of Tanzania, syndromic management of STIs was promoted and used in the family planning/maternal child health clinics resulting in a dramatic reduction of HIV transmission. There were several unique conditions that brought about its apparent success: the area had a relatively high prevalence of STIs, especially ulcerative STIs; the model used a highly accessible, well-focused, and well-executed community-based approach; and the clinics provided a high level of service to men.

Unfortunately, these conditions are rarely the programmatic norm. Take the results of the "mass treatment" study in the Rakai district of rural Uganda, for example. In this study everyone who was diagnosed with a "curable" STI by using syndromic management was treated twice and yet the study results showed that there was no impact on HIV transmission. If syndromic management were consistently reliable, the results should have been different. Results like these have had the effect of undermining confidence in the Mwanza findings.

Aggressive promotion of condoms should be a priority in the community-wide prevention strategy. One key to success is making condoms readily available in clinics, community-based distribution programs, and other settings (STI clinics, brothels, truck stops, and military facilities). Of course condom use should come up when promoting contraception. However, service providers should be sure to make the point that while many contraceptives are effective against pregnancy, only condoms are effective against STIs. Couples need to be counseled about use of condoms in conjunction with other contraceptive methods to prevent pregnancy and STIs. An alternative is that couples who chose to use condoms alone for contraception *and* STI prevention are aware that emergency contraception can also be used should they have a split condom or other mishap.

An especially important target in the general population for STI and HIV prevention is young adults and adolescents. While this age group is considered hard to reach, studies in Uganda demonstrated that behavior change messages aimed at this population—such as delaying the age of first intercourse for both men and women, using condoms, and eliminating sexual relations with non-regular partners—were quite successful.

For further reading

Shelton, James D., "Prevention First: A Three-pronged Strategy to Integrate Family Planning Program Efforts Against HIV and Sexually Transmitted Infections," *International Family Planning Perspectives*, Vol. 25, Number 3, September 1999.

Sloan, Nancy L. et al., "Screening and Syndromic Approaches to Identify Gonorrhea and Chlamydial Infection among Women," *Studies in Family Planning*, Vol. 31, Number 1, March 2000.

"Integration of Family Planning/MCH with HIV/STD Prevention—Programmatic Technical Guidance: Priority for Primary Prevention with a Focus on High Transmitters," USAID, December 1998.



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At a glance

NGO Networks for Health (*Networks*) is an innovative five year global health partnership created to meet the burgeoning demand for quality family planning, reproductive health, child survival, and HIV/AIDS information and services around the world. Funded by the United States Agency for International Development (USAID), the project began operations in June 1998. For more information, contact:

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Networks Technical Support Group encourages and supports health policy makers, program managers, and service providers to:

- become aware of the need to consider related social issues in all aspects of their work;
- understand that individual's perceptions can affect policy making, program planning, and clinical practice; and
- become comfortable in discussing a wide range of issues with colleagues, clients, and other persons at community levels as appropriate in their work.

